Health Maintenance Organization (HMO) & Alternative Health Care Financing and Delivery System (AFDS) Instructions for Application for a Michigan Certificate of Authority (COA)

HMOs and AFDs applying for a Michigan COA are subject to an application review process that involves the coordination of three different divisions within the Michigan Office of Financial & Insurance Services (OFIS). The three divisions are the Enterprise Monitoring and Insurance Examination Division, the Health Plans Division, and the Supervisory Affairs & Insurance Monitoring Division. OFIS provides all applicants with General Instructions and Division-Specific Instructions below.

Please be sure to adhere to the general and division specific instructions. The applicant is expected to demonstrate that each licensing requirement is met. ***Applications that do not meet these requirements will not be accepted.***

All applicants are expected to be familiar with Michigan's insurance laws and regulations. For information regarding how to obtain a copy of Michigan's laws and regulations please see Item #14 of the General Instructions.

Applicants should be aware that it typically takes at least six months for OFIS to complete its review of an application, approve provider contracts, and verify all licensure requirements are met including an adequate provider network. The timeframe for completing our review is very dependent on the quality of the application filed and the responsiveness of the applicant.

If you have any questions regarding the application or the review process, general or division specific, please have them addressed ***prior*** to submitting your application. All contact names and telephone numbers are provided in Item #13 of the General Instructions.

A. GENERAL INSTRUCTIONS (Exhibit A)

1. Submit a cover letter and two copies of the application to OFIS at the address shown in item #2 of the General Instructions. Place each copy of the application in a 3-ring binder with identifying information on the front and spine.

   The application should have four (4) exhibits. Each exhibit should contain the pertinent information and be organized as follows:

   Exhibit A: General Instructions
   Exhibit B: Enterprise Monitoring and Insurance Examination Division Specific
   Exhibit C: Health Plans Division Specific
   Exhibit D: Supervisory Affairs & Insurance Monitoring Division Specific

2. Submit the cover letter and two copies of the application to:

   Michigan Department of Labor & Economic Development
   Office of Financial and Insurance Services
   Enterprise Monitoring and Insurance Examination Division
   Attn: Sue Houseman
   P.O. Box 30220
   Lansing, MI 48909-7720

If submitting by overnight mail, please use this address:

Michigan Department of Labor & Economic Development
Office of Financial and Insurance Services
Enterprise Monitoring and Insurance Examination Division
Attn: Sue Houseman
611 W. Ottawa St., 3rd Fl.
Lansing, MI 48933

3. Please include a $500 check payable to the "State of Michigan".

4. Complete the application Cover Sheet (FIS 0273). Please be sure to provide all narratives and documents as instructed. Required information not applicable to your organization should be designated with the abbreviation "N/A" (not applicable). In addition, please provide an explanation as to why it is not applicable.

5. Designate an individual as the authorized representative on the Certificate of Appointment for Authorized Representative (FIS 0274). This person will be the contact with whom all regulatory staff will maintain communication and with whom responsibility for regulatory compliance is vested. Report any change in the designation of the authorized representative by submitting a new Certificate of Appointment for Authorized Representative form (FIS 0274) to the Department of Labor & Economic Growth, Office of Financial and Insurance Services, Enterprise Monitoring and Insurance Examination Division, Attn: Sue Houseman, P. O. Box 30220, Lansing, MI 48909-7720 or 611 W. Ottawa St., 3rd Floor, Lansing, MI 48933.

6. Notify the appropriate division of any significant changes that occur or are discovered during the application review period. Promptly submit amended forms if any changes occur. Please file amendments and subsequent submissions in the same manner as described in Item #1. Any amended documents are to be clearly dated and marked "AMENDED."

7. Place brochures, pamphlets and other items of various construction and size in an 8 ½" x 11" envelope. The envelope will serve as an individual page. Please label the envelope correctly and provide a brief description of its contents.

8. Do not include the following within the application packet:
   - paper clips
   - staples
   - highlighting with colored markers
   - bound documents (exception permitted for financial reports or audited financials)
   - two-sided copies
   - reduction of material to less than 70% of the original

9. On the first page of each contract/agreement please designate its status (draft, proposed, executed, etc.).

10. If necessary, please obtain a copy of the model trust indenture language, FIS 0284.

11. If necessary, please obtain a copy of the instructions for making a deposit with the State of Michigan, FIS 0285.

12. Maintain an exact copy of the application to facilitate questioning during the review process.

13. Direct any General or Division-Specific questions to the appropriate staff as follows:

    General Instructions
    Sue Houseman (517) 335-2062
    Enterprise Monitoring and Insurance Examination Division

    Enterprise Monitoring and Insurance Examination Division
    Sue Houseman (517) 335-2062

    Health Plans Division
    Joan Moiles (517) 241-4549

    Supervisory Affairs & Insurance Monitoring Division
    Dave Piner (517) 335-1734 or Julie Powers (517) 241-4277

14. Obtain a copy of the Michigan Insurance Code online or by contacting NILS Publishing at 1-800-423-5910.

15. Please be advised that compliance with the Michigan Insurance Code will likely be verified through an onsite examination prior to the issuance of a Certificate of Authority (COA).

16. If necessary, please contact the National Association of Insurance Commissioners at (816) 842-3600 to obtain a company code number upon issuance of a COA.

B. DIVISION-SPECIFIC INSTRUCTIONS

Division-Specific Instructions are available in the following sections:

Exhibit B - Enterprise Monitoring and Insurance Examination Division
Exhibit C - Health Plans Division
Exhibit D - Supervisory Affairs & Insurance Monitoring

Health Maintenance Organization (HMO) & Alternative Health Care Financing and Delivery System (AFDS) Instructions for Application for a Michigan Certificate of Authority (COA)

Section 1 - Articles of Incorporation

Provide a copy of the Articles of Incorporation, including all amendments thereto. Articles should be filed with the Department of Labor and Economic Growth, Bureau of Commercial Services, 2501 Woodlake Circle, P.O. Box 30018, Okemos, MI 48909.

The applicant is to be incorporated under the Business Corporation Act, Act. No. 284 of the Public Acts of 1972, Sections 450.1101 to 450.2098 of the Michigan Compiled Laws; the Nonprofit Corporation Act, Act No. 162 of the Public Acts of 1982, Sections 450.2101 to 450.3192 of the Michigan Compiled Laws; OR the Limited Liability Company Act, Act No. 23 of the Public Acts of 1993, Sections 450.4101 to 450.5200 of the Michigan Compiled Laws.

Section 2 - Bylaws

Provide a copy of the applicant's bylaws, dated and signed by a company officer. Bylaws should reflect, at a minimum: the location of the registered office; location of the books and records; governing body composition (1/3 of the membership of the board must include adult enrollees); process for nominating, electing and filling of vacancies; annual meeting date; quarterly board meetings; and definition of quorum.

Section 3 - Board of Directors and Officers

Provide a list of individuals responsible for the conduct of the applicant's affairs, including members of the board of directors, board of trustees or other governing body. Also provide a list of officers if the entity is a corporation, or a list of members or managers if the entity is a limited liability company. The list should include each individual's name, title, personal address, and term of office. Ensure that each list includes an effective date.

Section 4 - Enrollee Board Member Election Procedure

Provide a written policy and election procedure for the election of adult enrollees to the governing board. The election must occur within the first 12 months of operation. Pursuant to Section 3511 of the Michigan Insurance Code, a governing body shall have a minimum of 1/3 of its membership consisting of adult enrollees who are not compensated officers, employees, stockholders who own more than 5% of the organization's shares, or other individuals responsible for the conduct of, or financially interested in, the organization's affairs.

The procedure shall provide:

1. Notice to subscribers for the nomination of adult enrollees.
2. Composition of nominating committee, its purpose and selection criteria for nominees.
3. Notification to selected nominees.
4. Notification to subscribers of the election process.
5. Opportunity for subscribers to vote for adult enrollees through a balloting procedure. Include timelines for issuing and receiving completed ballots.

6. Tabulation of votes and how tie votes will be resolved.
7. Notification to elected adult enrollees.
8. Notification of election results to subscribers. Notification should include a current list of all governing body members with adult enrollee board members identified.
9. Term of office of adult enrollee board members. Enrollee board members shall hold office for three years after their election, except that the terms of office following the first enrollee election may be adjusted to allow the terms of adult enrollee board members to expire on a staggered basis.
10. How vacancies will be handled. A vacancy among adult enrollee board members shall be filled by appointment by a simple majority of the remaining enrollee board members, from individuals meeting the qualifications identified in this procedure. A vacancy shall be filled only for the unexpired portion of the original term.

Section 5 - Conflict of Interest

Provide a conflict of interest policy and procedure that provides full disclosure and discovery of any present or potential conflict of interest for any of the following persons: promoters, incorporators, a partnership or association, directors, trustees, members of the governing body, officers of the HMO/AFDS, chief actuary, general counsel, and controller. The policy and procedure should state that any conflict would be made known to the governing body within 30 working days of the date of discovery. The policy is to be dated and signed by a company officer.

Health Maintenance Organization (HMO) & Alternative Health Care Financing and Delivery System (AFDS) Instructions for Application for a Michigan Certificate of Authority (COA)

Section 1 - Rates

Provide the following information:

1. A schedule of rates, including rates for base plans and all optional riders.

2. Supporting methodology used in the development of all rates. This methodology must include the projected utilization (per 1,000 members per year) by service type and the projected cost per service. Where applicable, the cost data must be consistent with the payment methodology reflected in the applicant's provider agreements. The rates produced by this rating methodology must also be consistent with the revenue projections found in the financial plan. [Section 3521]

3. An actuarial certification or other narration from the applicant that explains the method used in the development of the projected cost and utilization of benefits as well as the applicant's administrative expenses.

4. A written description of the methodology used in determining actual rates charged to groups and individuals. This must include any factors used in the adjustment of rates (e.g. industry or age/gender rating). More than one rating methodology may be proposed (e.g. different rating methodologies may apply to groups of different sizes); however, all groups within any given size must be rated using the same methodology. The applicant must demonstrate that any such method used to adjust the actual rates charged is revenue neutral (on an aggregate basis). [Section 3519]

5. Contract mix assumptions and rate slope (relationship between single, two person, and family rates).

Section 2 - Marketing Plan

Provide the applicant's marketing and enrollment plan that includes the following information:

1. A description of the data, information, methodology, and assumptions used in projecting enrollment levels by enrollment category, including, at a minimum, an annual enrollment projection for the first three years of operation.

2. A description of the proposed marketing, sales and enrollment methods, including a description of whether the plan will be marketed and sold by staff, marketing representatives, agents, or both.

3. A copy of established guidelines used to ensure accountability of marketing and sales representatives.

4. All proposed promotional, advertising, and informational materials including copies of print ads and/or scripts for radio and television media, if applicable. A health maintenance organization shall not use in its name, contracts, or literature the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state. [Section 3505(3)] Any enrollee incentives shall comply with Insurance Bulletin No. 97-04.

5. All subscriber applications or related forms including employer contracts/ agreements.

6. A description of the enrollment process.

7. The projected timeframe for processing enrollment applications.

8. Timeline(s) the applicant will have for issuing new subscribers' member material, including but not limited to the following: certificate of coverage, membership card and provider director.

Section 3 - Service Area

Pursuant to Section 3509 of the Michigan Insurance Code, the applicant shall provide a description of the requested service area(s). The applicant shall identify each full and/or partial county in the requested service area. If the applicant is requesting approval to serve a partial county, the requested areas within the partial county must be identified by townships and cities. If the applicant is requesting non-contiguous service areas, each service area shall be described separately. The applicant shall provide state and county map(s) showing the boundaries of the requested service area(s).

Section 4 - Contracted Provider Network

An applicant must demonstrate that it has an adequate contracted provider network on provider contract formats approved by OFIS demonstrating compliance with Sections 3513(2)(b) and (d), 3529(2), and 3530 of the Michigan Insurance Code.

The applicant must demonstrate that it has contracted with a comprehensive range of providers offering primary care, specialty, facility and ancillary services that are readily accessible and available to enrollees throughout the applicant's service area(s). A COA will not be issued until an applicant has at least one service area with an adequate contracted and credentialed provider network. Provide the following information:

1. A description of the ability to provide, within the requested service area, treatment of emergency episodes of illness or injury to enrollees 24 hours a day and 7 days a week. [Section 3513(2)(b) and (d)]

2. A description of the ability to provide, outside the applicant's approved service area, treatment of emergency episodes of illness or injury to enrollees 24 hours a day and 7 days a week. [Section 3513(2)(d)]

3. A description of the provider-covered person ratios by primary and specialty care provider-covered person ratios.

4. A description of the standards of geographic accessibility to primary care physicians/sites, specialists and hospitals. The Health Plans Division will not approve any service area for which the nearest contracted acute-care hospital is more than 30 minutes away. Exceptions may be allowed in rural areas where no hospital exists within a 30 minutes travel time to requested area. [Section 3530(1)]

5. A description of the process and standards to establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees. [Section 3530(3)]

6. A description of the standards of accessibility regarding availability of routine and urgent appointments, expected patient waiting times for routine and urgent appointments. [Section 3530(1)]

7. A written attestation from the authorized representative that if there is an insufficient number or type of participating providers in its contracted provider network to provide a covered benefit, the applicant shall ensure that the enrollee will obtain the covered benefit in a timely manner, geographically accessible, and at no greater cost than if the benefit were obtained from participating providers. [Section 3530(2)]

8. Complete the below forms, or provide an initial provider directory, or equivalent document listing all providers by each county within the requested service area. At the time of filing the application, the listed providers should have executed letters of intent to become a contracted provider.

    a. Summary of primary care and specialist physicians by each county in the requested service area. [FIS 0276 for a HMO applicant; FIS 0277 for an AFDS applicant]
    b. Profile of ancillary providers by each county in the applicant's requested service area. [FIS 0282]
    c. Profile of hospitals by each county in the requested service area including the hospital's listing from the most recent American Hospital Association Directory. [FIS 0283]

9. Prior to the issuance of a certificate of authority, the applicant shall submit the above FIS forms for all providers that have been contracted on OFIS approved provider contracts. In addition, form FIS 0281 (Profile of Contracted Health Professionals) shall be filed. [Section 3529(2)]. An applicant must also have completed its credentialing verification process for each listed provider. [Section 3528]

10. County specific maps showing the locations of the contracted providers identified in forms FIS 0281, 0282 and 0283. Include designated symbols and corresponding index for the identified providers.

11. Evidence that the applicant has provided an initial 60-day application period during which providers may apply to the applicant to become an affiliated provider. [Section 3531(7)]

Section 5 - Provider Contracts, Agreements and Arrangements for Service

Please provide all current, or proposed, standard provider contract formats and agreements. [Section 3529(6)] Typical contract formats include, but are not limited to, the following:

1. Physician (primary care)
2. Physician (specialist)
3. Hospital
4. Pharmacy
5. Physician hospital organization (PHO)
6. Independent practice association (IPA)
7. Ancillary services (e.g. used for home health care, durable medical equipment, ambulance, etc…)

Each model contract must include a format of each attachment, exhibit or addenda that is referenced in the model contract.

All contracts must contain a listing of covered services to be provided in conjunction with the proposed contract and the corresponding reimbursement methodology(ies) to be used.

Contracts that propose sharing risk with a provider or provider organization (e.g. IPA, PHO, Pharmacy Benefit Manager) must disclose all proposed risk provisions, including risk-sharing information pertaining to withhold amounts, fund allocations, risk corridors (may be expressed in a range) and the allocation of deficits and surplus. The applicant must also describe any method(s) used in the settlement of any risk-sharing pools or other risk-sharing arrangements.

For primary care physician contracts there must be an element of risk once the number of members assigned to the primary care physician reaches 250 or more members. Elements of risk may include, but are not limited to, a withhold of 5% or more from a fee-for-service arrangement, or a capitation arrangement.

Model contracts to be used by the applicant to contract with a provider organization (PHO, IPA etc…) must contain all underlying contracts between the provider organization and its affiliated providers (including the reimbursement arrangements). All such underlying contracts must also meet the minimum requirements of Section 3529 of the Michigan Insurance Code.

Section 6 - Subscriber and Group Contracts and Riders

Provide all proposed subscriber contracts, (group, individual, conversion, point-of-service etc…) riders, and amendments that, at a minimum, meet the requirements of Section 3402, Section 3523 and contain the requirements pursuant to Section 2212a and applicable sections of Chapters 22 and 34, and 35 and of the Michigan Insurance Code. A listing of required elements necessary in a subscriber certificate are identified in Attachment 1 of this document.

Provide the applicant's enrollment application. [Section 3523(2)]

Section 7 - Quality Assessment Program

Provide approved policy and procedures for the applicant's quality assessment program that contains, at a minimum, the following information pursuant to Section 3508(1) of the Michigan Insurance Code:

1. Assessment of the quality of health care provided to enrollees.

2. Systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements.

In addition to the above requirements, provide approved policies, procedures and documentation addressing the following:

1. How the applicant will monitor its quality assessment program to ensure the provision of quality health care services.

2. The governing body's accountability for the quality assessment program, including how the governing body will assure quality assessment policies and procedures are adopted, implemented, and revised as necessary.

3. Describe how the quality assessment program results will be routinely reported to the governing board, plan administration, and network providers.

4. Provide a copy of the medical director's Michigan medical license, vitae, and job description.

5. Provide an organizational chart of the applicant's current and/or future quality committee structure. Identify filled and vacant positions.

Section 8 - Quality Improvement Program

Provide a description, or approved policy and procedures, for the applicant's quality improvement program that contains, at a minimum, the following information pursuant to Section 3508(2) of the Michigan Insurance Code:

1. Design, measure, assess, and improve the processes and outcomes of health care as identified in the program. The quality improvement program shall be under the direction of the medical director and include:

    a. A written statement of the program's objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, and performance improvement activities.
    b. An annual effectiveness review of the program.
    c. A written quality improvement plan that, at a minimum, describes how the applicant analyzes both the process and outcome of care, identifies the targeted diagnoses and treatment to be reviewed each year, uses a range of appropriate methods to analyze quality, compare program findings with past performance and internal goals and external standards, measures the performance of affiliated providers, and conducts peer review activities.

In addition to the above requirements, provide description, or the applicant's approved policies and procedures, addressing how the applicant will do the following:

1. Adopt and communicate clinical practice and preventive guidelines to its providers.
2. Use clinical practice and preventive guidelines to assess and improve health care service quality.
3. Conduct peer review process, responsibilities, and evaluation of corrective actions.
4. Ensure health study sampling methodology is valid and based on the applicant's entire population.
5. Provide members with preventive health care education.
6. Conduct utilization review. Also describe, identify or provide a copy of the measurable criteria used for making utilization management decisions.
7. Conduct prior authorization for elective inpatient admission and the length of time necessary to perform this function.
8. Conduct inpatient hospitalization concurrent review and use appropriate length of stay norms (as necessary).
9. Develop or adopt inpatient length of stay norms.
10. Assess potential over and under utilization of services.
11. Conduct the applicant's case management program, and how it will identify and manage enrollees with complex health care conditions.

Section 9 - Health Professional Credentialing

Provide a credentialing verification process, or the applicant's approved policy and procedures, for credentialing and re-credentialing all contracted health professionals. The policies and procedures must address and contain all requirements pursuant to Section 3528 of the Michigan Insurance Code.

Describe, or provide the applicant's approved policies and procedures, addressing how the applicant will ensure that the contracted primary care physician offices are maintained in a safe and sanitary condition in a manner consistent with public health and welfare and constructed to be free from hazards to enrollees, staff and visitors.

Provide a copy of the site visit tool used to conduct physician office site visits.

Section 10 - Enrollee Clinical Records

Provide information, or approved policies and procedures that address the requirements and oversight of enrollee clinical records including at a minimum the following:

1. Provide the polices and procedures used to establish standards for medical records ensuring the following:

    a. Medical records, including external referral reports, are maintained consistent with accepted professional standards and practices.
    b. Medical records are readily accessible and organized to facilitate retrieval and information compilation.
    c. Medical records are treated in a confidential manner and are disclosed only to authorized persons.
    d. There is an appropriate retention plan for inactive enrollee clinical records.

2. Describe the process to communicate medical record standards to network physicians.

3. Describe how the applicant will monitor and ensure its network providers maintain medical records in accordance with its standards and correct identified deficiencies.

Section 11 - Complaint and Grievance Procedure

Provide grievance procedures that address the requirements contained in Section 2213 of the Michigan Insurance Code as well as the Patient's Right to Independent Review Act (PRIRA), Act 251 of the Public Acts of 2000, Sections 550.1901 to 550.1929 of the Michigan Compiled Laws. A description of the elements necessary to comply with Section 2213 is identified in Attachment 2 of this document. Section 2213 and the PRIRA statute can be downloaded from the Internet at www.legislature.mi.gov/.

Supervisory Affairs & Insurance Monitoring Division (Exhibit D)

Health Maintenance Organization (HMO) & Alternative Health Care Financing and Delivery System (AFDS) Instructions for Application for a Michigan Certificate of Authority (COA)

Section 1 - Disclosure Statements & Fingerprint Cards

Please provide a disclosure statement using the NAIC Biographical Affidavit for each individual responsible for the conduct of the applicant's affairs, including members of the board of directors, board of trustees, or other governing body. You can access the form at the following website: www.naic.org/ucaa/forms/forms.htm. Please provide disclosure statements for officers if the entity is a corporation or members if the entity is a limited liability company. Please be sure to also include a disclosure statement for the entity's medical director as well. Disclosure statements should contain original signatures.

Fingerprint cards for the individuals cited in the above paragraph should be provided. Please call Sue Houseman at (517) 335-2062 for details.

Section 2 - Organization Charts

Please provide organization and function charts. Each chart should be clearly labeled and have an effective date.

- The *organization chart* presents the identities of, percentage ownership of, and interrelationships between the applicant, its subsidiaries, its parent company, and any other affiliates of the applicant. The ultimate controlling person should be identified at the top of the chart. All ownership interests of 10% or more must be identified. Any legal entity (or person who is not an employee) responsible for administration or fiscal affairs of the applicant must also be identified. Affiliate means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

  The Company should supply an organization chart in accordance with the NAIC's Annual Statement Instructions for Schedule Y, Part 1.

- The *administrative organization chart* presents the interrelationships of departments and positions within the firm. Identify officers and personnel assigned to the positions.

- The *function chart* describes the job functions of the positions identified in the administrative organization chart.

Section 3 – Plan of Operation

Provide a narrative describing the applicant's operations. The plan of operation should cover the highlights and essential features of the information provided in the other portions of the application. At a minimum, the plan of operation must address these key questions or areas:

1. Who is providing the initial funding to start this operation?

2. What are the options for raising additional capital, if necessary?

3. How does the entity intend to comply with Sections 3559(1), 3559(3), and 3561 of the Michigan Insurance Code?

4. How will the statutory deposit requirement be satisfied? Will the deposit be placed with the Michigan Department of Treasury (please see FIS 0285) or Third Party Trustee (please see FIS 0284)?

5. Will the applicant be a for-profit or non-for-profit entity?

6. Will the applicant be a staff, network, independent practice association (IPA), group or combination model HMO?

7. Include a detailed discussion of the corporate organizational structure. This discussion should clearly identify any parent and affiliated entities and any ownership or contractual relationships with these entities. The discussion should clearly identify what individuals or corporations own the entities in the corporate structure. Also, any affiliated relationships or transactions should be included. Any services provided by affiliates must be covered and substantiated with a written agreement that clearly defines the services to be provided, outlines compensation for services rendered, and states when and how balances would be settled.

   All affiliated service agreements should be submitted (see below - Section 4). The applicant should note if it has any direct involvement (proprietary, voting or other decision-making authority) in policymaking or operation of another organization or if any organization has similar control over the applicant's operations. The name, address and FEIN number should be provided for all affiliates.

8. Identify and describe the products to be marketed and sold. Please provide income statement projections for each product for five years. Please see FIS 0317 located in the OFIS Forms & Instructions Booklet for income statement format. Please be sure to comply with statutory accounting principles.

9. Include a description of how the applicant will maintain compliance with the books and records requirement of Section 3548 and Section 5256 of the Michigan Insurance Code.

10. Identify third party administrators (TPAs) that will be utilized by the applicant. It is the responsibility of the applicant to ensure all TPAs are properly licensed.

Section 4 - Leases, Mortgages, Management Contracts, & Insurance Coverages

Provide all affiliated agreements for leases, mortgages, loans, grants, management service agreements, reinsurance agreements, liability coverages, or other documents to which the applicant is a party.

Designate the status (draft, proposed, in negotiation, executed) of each contract or service agreement. All executed agreements must be current and signed with all penned changes to the agreement initialed by both parties.

Management Agreement

A management agreement should contain the following components:

1. Services to be provided must be specific and the criteria used to evaluate performance under the agreement must be stated.
2. All books and records must clearly belong to the applicant.
3. If the entity providing management services is located outside of Michigan, complete access to records *must* be available to the Office of Financial & Insurance Services.
4. Both parties must be able to terminate the agreement.
5. Fees for services rendered should be easily ascertained and reasonable. Balances must be settled timely. How and when balances are settled should be stated.

(Note: If a management company processes claims on behalf of the applicant, that management company must be licensed as a TPA pursuant to Sections 3543 and 550.901 of the Michigan Insurance Code.)

Reinsurance Agreements

Pursuant to Section 3559(1) of the Michigan Insurance Code, HMO's are required to obtain a reinsurance contract or establish a plan of self-insurance as may be necessary to ensure solvency or protect subscribers in the event of insolvency. If the HMO wishes to obtain a reinsurance contract, the agreement must be with a reinsurer authorized or eligible to transact insurance in Michigan. Furthermore, the policy must contain an endorsement for insolvency, which is essentially a continuation of benefits provision required by Section 3561 of the Michigan Insurance Code. Please be sure to include evidence of coverage. Provide the reinsurance agreement or, if the coverage is not purchased until licensed, a binder from the reinsurer that is executed upon licensure. (Note: Reinsurance coverage for HMO/AFDS is not similar to reinsurance coverage for a traditional insurer, but more a stop-loss coverage that limits or caps an HMO's/AFDS' losses above certain individual and aggregate limits.)

Insurance Coverages

Applicants are required to maintain insurance *coverage* pursuant to Section 3559(3) of the Michigan Insurance Code. The applicant shall maintain insurance coverage to protect from excessive loss, which includes, but is not limited to, fire, theft, general liability, errors and omissions, directors and officers, fidelity, and malpractice insurance. Clearly label the type of insurance coverage provided. Include certificates of coverage for all insurance.

Section 5 - Financial Statements

Please provide the following:

1. The applicant's independent audited financial statements for the most recent fiscal year and subsequent monthly financial statements up to the most recent month available. If the audited financial statements are not available, please provide unaudited financial statements. Please be

advised that projections will be weighed more heavily for determining the entity's suitability for a COA if audited financial statements are not available. All financial statements must be prepared in accordance with statutory accounting principles.

2. The financial statements of each stockholder and the entity's Ultimate Controlling Person (UCP). If the immediate owner(s) or the UCP is a corporation, please submit its audited financial statements. If the audited financial statements are on a consolidated basis, please be sure to include the consolidating work sheet in the notes. If the immediate owner(s) or the UCP is an individual, please submit their personal financial statements.

3. The entity's most recent annual and quarterly financial statements prepared on the "orange blank." Please be sure all financial statements have original signatures. The NAIC Quarterly and Annual Statement Instructions, as well as, the NAIC Accounting Practices & Procedures Manual can be purchased from the NAIC. To order, please contact the NAIC Publications Department at (816) 783-8300 or visit the NAIC's product and services division to access its catalogue. In addition, please be sure that the financial statements are prepared in accordance with the OFIS Forms & Instructions Booklet.

4. The entity's most recent actuarial opinion, if available. Please be sure the document contains an original signature(s). Please be sure that the actuarial opinion is completed in accordance with the requirements outlined in the NAIC Accounting Instructions and the OFIS Forms & Instructions Booklet.

5. The entity's most recent annual or quarterly FIS 0317, 0320, 0321, contained in the OFIS Forms & Instructions Booklet if available. Please be sure all documents have an original signature(s).

NOTE: A preliminary review upon receipt of your application will be performed to determine compliance with working capital and net worth requirements of Sections 3555 and 3551 of the Michigan Insurance Code. The application will not be accepted if the minimum requirements are not met. (A plan to meet the requirements is NOT acceptable.)

Section 6 - Accounting Procedures

Provide a description of the accounting procedures and practices to be used including written policies and procedures for expenditure control and approval, and premium collection. Describe in detail how claims will be accounted for and how the applicant will monitor claims payable particularly incurred but not yet reported claims (IBNR). In your description of the accounting systems to be used, clearly indicate the individual(s) that are responsible for each function.

Section 7 - Financial Plan

The financial plan should provide adequate detail to allow a review of the applicant's financial viability and profitability on a long-term basis. The company's fiscal year must be on a calendar year basis. At a minimum, the financial plan should include the following:

1. Five-year projected balance sheet, income statement and cash flow statement. The first year's projections should be broken down on a quarterly basis. These projected financial statements should be prepared on an accrual basis and in accordance with statutory accounting principles.

2. The applicant's most recent RBC Report and five-year projection of RBC Ratios. For assistance with obtaining the necessary materials for computing the RBC ratio, please contact the National Association of Insurance Commissioners at (816) 783-8300 or at the website of the NAIC's products and services division.

3. Demonstration that the applicant meets all financial requirements at the time the application is submitted and will stay in compliance with all financial requirements.

4. Description of methods, assumptions and projections used in the development of a financial plan such as anticipated utilization, expansion, and inflationary factors, etc.

5. Description of all assets that account for the initial surplus of the applicant.

6. Appropriate supporting financial, statistical or actuarial documentation. At a minimum, this support should include the method and assumptions inherent in the development of IBNR.

7. Identification of the current and/or prospective owners of the applicant and the source of the funding.

8. Documentation of the source of any additional funding projected in the financial plan.

9. Provide documentation that illustrates compliance with the minimum surplus requirements set forth in Section 3551 of the Michigan Insurance Code. For an AFDS, minimum surplus requirements are outlined in Bulletin 2001-05-INS.

10. Demonstrate compliance with the positive working capital requirement of Section 3555(b) and that the appropriate deposit amount as required by Section 3553 of the Michigan Insurance Code is satisfied. The deposit must be made prior to issuance of the Certificate of Authority.

Section 8 - Management Information System

Provide a description of management information system(s) to be used, including manual and machine systems. Include a system overview or flow chart, copies of input documents and a narrative of system procedures. Describe in detail the systems to be used to account for the general ledger, claims and premiums. The applicant must be able to adequately demonstrate it is capable of handling membership, marketing, claim processing, accounting and planning functions.

Application Forms

FIS-0273 HMO/AFDS Application for Certificate of Authority
FIS-0274 Appointment for Authorized Representatives
FIS-0276 HMO Summary of Contracted Health Professionals
FIS-0277 AFDS Summary of Contracted Health Professionals
FIS-0281 HMO/AFDS Profile of Contracted Health Professional
FIS-0282 Summary of Ancillary Providers
FIS-0283 Summary of Contracted Hospitals
FIS-0284 Model Trust Indenture
FIS-0285 Statutory Deposit Instructions

Health Maintenance Organization (HMO)
Alternative Health Care Financing and Delivery System (AFDS)

Subscriber Contract

The subscriber contract shall address the following requirements contained in Section 2212a of the Michigan Insurance Code:

1. Provide a written form, in plain English, to enrollees upon enrollment that describes the terms and conditions of the applicant's policies and certificates. The form shall provide a clear, complete, and accurate description of the following, as applicable:

    a. Service area.

    b. Covered benefits, including, when applicable, a statement regarding prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

    c. Emergency health coverages and benefits.

    d. Out-of-area coverages and benefits.

    e. Explanation of the enrollee's financial responsibility for co-payments and any other out-of-pocket expenses.

    f. Provision for continuity of treatment in the event a provider's participation terminates during the course of an enrollee's treatment by that provider.

    g. Telephone number to call to receive information concerning grievance procedures.

    h. How the covered benefits apply in the evaluation and treatment of pain.

    i. Summary listing of the following information:

        (1) Current provider network in the applicant's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.
        (2) Professional credentials of participating health professionals.
        (3) Licensing verification telephone number for the Department of Community Health.
        (4) Prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(5) Indication of the financial relationships between the applicant and any closed provider panel.
(6) Provide a telephone number and address to obtain from the applicant additional information concerning the items described in the above subdivisions.

2. The subscriber contract shall address the following requirements contained in Section 3523(3)(a-q) of the Michigan Insurance Code:

a. Name and address of the organization.

b. Definitions of terms subject to interpretation.

c. Effective date and duration of coverage.

d. Conditions of eligibility.

e. Statement of responsibility for payments.

f. Description of specific benefits and services available under the contract within the service area, with respective co-payments and deductibles.

g. Description of emergency and out-of-area services.

h. Specific description of any limitation, exclusion, and exception, including any preexisting condition limitation, grouped together with captions in boldface type.

i. Covenants which address confidentiality, an enrollee's right to choose or change the primary care physician or other providers, availability and accessibility of services, and any rights of the enrollee to inspect and review his or her medical records.

j. Covenants of the subscriber shall address the following subjects:

(1) Timely payment.
(2) Non-assignment of benefits.
(3) Truth in application and statements.
(4) Notification of change in address.
(5) Theft of membership identification.

k. Statement of responsibilities and rights regarding the grievance procedure.

l. Statement regarding subrogation and coordination of benefits provisions, including any responsibility of the enrollee to cooperate.

m. Statement regarding conversion rights.

n. Provisions for adding new family members or other acquired dependents, including conversion of individual contracts to family contracts and family contracts to individual contracts, and time constraints imposed.

o. Provisions for grace periods for late payment.

p. Description of any specific terms under which the applicant or the subscriber can terminate the contract.

q. Statement of the non-assignability of the contract.

3. Each of the applicant's subscriber contracts shall address the following requirements contained in Chapters 34 and 35 of the Michigan Insurance Code:

a. Policy cancellation (non-group). [Section 3409]

b. Grace period. [Section 3410]

c. Co-payments for basic health services, excluding deductibles, shall be nominal, shall not exceed 50% of the applicant's reimbursement to an affiliated provider for providing the service to an enrollee, and shall not be based on the provider's standard charge for the service. [Section 3515(2)]

4. The applicant's subscriber certificate shall include language describing the benefit mandates as required in Chapters 34 and 35 of the Michigan Insurance Code:

a. Prosthetic devices to maintain or replace body parts of an individual who has undergone a mastectomy. [Section 3406a]

b. Mental health services. [Section 3406b]

c. Hospice care. [Section 3406c]

d. Breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services; coverage for breast cancer screening and mammography. [Section 3406d]

e. Drugs used in antineoplastic therapy and cost of its administration. [Section 3406e]

f. Direct access by enrollee to an obstetrician-gynecologist. [Section 3406m]

g. Coverage for equipment, supplies and educational training for the treatment of diabetes. If outpatient pharmaceutical coverage is provided, include coverage for insulin, non-experimental medications for controlling blood sugar, and medications used in the treatment of diabetes related conditions. [Section 3406p]

h. The subscriber contract shall, at a minimum, provide for the following basic health maintenance services. [Section 3519(3)]

(1) Physician services including consultant and referral services by a physician, but not including psychiatric services. [Section 3501(b)(*i*)]
(2) Ambulatory services. [Section 3501(b)(*ii*)]
(3) Inpatient hospital services, other than those for the treatment of mental illness. [Section 3501(b)(*iii*)]
(4) Emergency health services. [Section 3501(b)(*iv*)]
(5) Outpatient mental health services, not fewer than 20 visits per year. [Section 3501(b)(*v*)]
(6) Intermediate and outpatient care for substance abuse. [Section 3501(b)(*vi*)]
(7) Diagnostic laboratory and diagnostic and therapeutic radiological services. [Section 3501(b)(*vii*)]
(8) Home health services. [Section 3501(b)(*viii*)]
(9) Preventive health services. [Section 3501(b)(*ix*)]

Provide a separate index identifying where each of the above items is located in the subscriber contract.

Health Maintenance Organization (HMO)
Alternative Health Care Financing and Delivery System (AFDS)

Grievance Documentation

Section 2213 of the Michigan Insurance Code, states that the grievance procedure shall meet the following requirements:

1. Provides for a designated person responsible for administering the grievance system and serving as the Office of Financial and Insurance Services' contact person.

2. Provides a designated person or telephone number for receiving complaints. Fax and e-mail would also be helpful, if available.

3. Ensures full investigation of a complaint.

4. Provides for timely notification to the enrollee as to the progress of an investigation.

5. Provides an enrollee the right to appear before the Board of Directors or designated committee or the right to a managerial-level conference to present a grievance.

6. Provides for notification in plain English to the enrollee of the results of the HMO's or AFDS' investigation and for advisement of the enrollee's right to request a review of the grievance by the Commissioner or by an independent review organization under the Patient's Right to Independent Review Act. (Sections 1901 to 1929)

7. Provides summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the Commissioner on forms provided by the Commissioner.

8. Provides for periodic management and governing body review of the data to assure that appropriate actions have been taken.

9. Provides for copies of all complaints and responses to be available at the principle office of the HMO or AFDS for inspection by the Commissioner for two years following the year the complaint was filed.

10. When an adverse determination is made, a written statement containing the reasons for the adverse determination will be provided to the enrollee along with written notifications as required under the Patient's Right to Independent Review Act. (Section 1907)

11. That a final determination will be made in writing by the HMO or AFDS not later than 35 calendar days after a formal grievance is submitted in writing by the enrollee. The timing for the 35 calendar day period may be tolled, however, for any period of time the enrollee is permitted to take under the procedure and for a period of time that shall not exceed 10 business days if the HMO or AFDS has not received requested information from a health care facility or health professional.

12. That a determination will be made by the HMO or AFDS not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the enrollee may request a determination of the matter by an independent review organization under the Patient's Right to Independent Review Act. (Section 1913) If the determination by the HMO or AFDS is made orally, the HMO or AFDS shall provide a written confirmation to the enrollee not later than 2 business days after the oral determination.

13. That the enrollee has the right to a determination of the matter by the Commissioner or his or her designee or an independent review organization under the Patient's Right to Independent Review Act. (Sections 1901 to 1929)